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ABSTRACT

The Kreger Model is a developmental approach to the identification and assessment of, and intervention with, emotionally disturbed children. Principles fundamental to a developmental paradigm are outlined, and assumptions fundamental to the Kreger Model pointed out. It is explained that the Kreger Model is a direct response to criteria which include a method to evaluate the quantitative and qualitative aspects of the child's psychological functioning. Using an integration of the major works in emotional, social, and cognitive development, the authors describe the construction and purposes of the model. An assessment instrument, based on the model, is discussed in terms of styles of behavioral patterns, and use of observational techniques. The model is also considered for facilitating emotional, social, and related cognitive functioning. It is explained that after assessing the child's functoning in the various areas and obtaining a summative profile of his baseline abilities, the starting point for meeting needs and for the interventions is pinpointed. Directions for using the intervention design are given along with a verbatim description of the suggested programmatic interventions to be used with a disturbed child. Also provided are guidelines for using the model in designing individualized educational plans, and for record keeping and monitoring progress. (SW)

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A Systematic, Developmental Approach for Identification, Assessment and Intervention of Psycho-Social Problems in Children

Linda R. Kreger and Robert D. Kreger

ABSTRACT

In an effort to further promote the growing use of a developmental approach to the identification, assessment and intervention of emotionally disturbed children, the authors discuss a model which is totally theoretically based. They provide a review of the literature that includes the rationale and appeal for a systematic developmental paradigm that address both the quantitative and qualitative properties necessary in correctly identifying, assessing and treating emotional-social and related cognitive functioning in children. Using an integration of the major works in emotional, social and cognitive development, the authors describe the construction and purposes of their model which is especially useful when addressing the needs of programs for emotionally disturbed children (I.E.P.'s, parent training, evaluating specific stages and specific forms of delay and aberrance, etc.).

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Paper presented at the Annual Convention of the Council for Exceptional Children (62nd, Washington, DC, April 23-27, 1984)

The need for treatment models geared to measure more accurately the actual developmental level and form of emotional, social, and related cognitive functioning of emotionally disturbed and other children for use by professionals and parents has been evident for years (Achenbach, 1974; Garfunkel, 1976; Quanty & Davis, 1974; and others) as has the need for systematic therapeutic models of interventions. Quanty and Davis (1974) found that there is no available measure to which one could relate and compare behavioral phenomena along true developmental dimensions in the psycho-social realm. They state:

> If it were possible to identify a child's present developmental stage . . . teachers and parents would be able to determine the child's current needs and provide experiences that would allow him to . . . . Unfortunately, there is no behavior dictionary that would allow one to look up persistent behavior patterns and discover that they are indications that the child is in Stage . . . and should be given . . . (pp. 160-161).

Garfunkel (1976) also addressed the need for such a measure and speculated as to the role of the special educator in

helping to advance such a system.

> . . . there is no workable description diagnosis system that can be freely and constructively shared with teachers so that degree and kinds of disturbances (and other disabilities) can be more readily identified and serviced. Such a system will probably have to be evoked from a collaboration between special educators who are sensitive to disability and regular class teachers who are more sensitive to normal behavioral variations. . . . since teachers are the most sustained and immediate observers of interventions, it is probable that such connections between categories and interventions will not be inferred without the continuous involvement of teachers (p. 126).

While developmental approaches to assessment and treatment are used extensively with physical, language, mental or sensory handicaps (Dale, 1976; Gesell & Amatruda, 1974; Kephart, 1955; Schafer & Moersch, 1977) there has been little extension of this approach in the area of psycho-social (used interchangedly with social, emotional and related cognitive) development outside of psychoanalytic psychiatry (A. Freud, 1965, 1962; Nagera, 1963). The only publicized model attempting to meet some of these needs is the Developmental Therapy work of Mary Wood(1975A). While

Wood's Developmental Therapy model has offered some interesting and stimulating advances in this area, critical analysis (Kavale, 1978; Kreger, Linda, 1980) and recent research (Center, 1981) raise serious concerns as to its theoretical, developmental and practical validity. Kavale (1978) states:

> . . . the developmental therapy model developed by Wood and her colleagues should be approached with caution. Although the model is neatly packaged, the contents are found to be less than satisfactory when the packaging is removed. The model possesses difficulties from both theoretical and practical points of view which seriously limit its usefulness. Consequently, those involved with emotionally disturbed children should be circumspect regarding developmental therapy. Our task is too important for us to be swayed by unproven claims about children and treatment (p. 330).

Wood is aware of some of the shortcomings of her model and together with Swan (Wood & Swan, 1978) calls for future research in this area which should include: (1) the need to develop techniques to measure patterns of behavior, and (2) the need to discover the relationship between emotional disturbance and developmental tasks which "remains unclear."

The Kreger Model: A Developmental Approach for Assessment and Intervention with Emotionally Disturbed, Exceptional and Normal Children in Emotional and Social Realms, (R. Kreger and L. Kreger, 1982), particularly useful for meeting the needs of emotionally disturbed children, addresses these issues and includes other crucial ingredients for a developmental paradigm. (As indicated in the title, the developmental nature of this model makes it applicable for use with normal and/or exceptional children in areas of assessment or intervention for identification, remediation or prevention purposes. However, the purpose of this article and the motivating impetus behind the design of this model is to discuss its usefulness with emotionally disturbed children).

Developed over several years, this model has been used successfully by the authors with a number of children with emotional problems (L. Kreger, 1980). The Kreger Model systematically bridges the gap between theory and practical application. The assessment and interventions are extrapolated from an integration of major developmental theories in emotional, social and related cognitive development. They are based upon known levels of functioning and the concomitant needs of children at various points in psychological development. A conceptual base thus is the foundation for the model; it is not a model of self-styled techniques found useful with a narrow sample of

children. The professional can adapt the model designing his/her own "corrective experience" for the child as long as the basic ingredients pertinent to a developmental approach remain. This article will explain the construction of the model as well as advocate for a developmental approach in the areas of prevention, assessment and intervention with emotionally disturbed children. Prior to providing the reader with a detailed explanation concerning the various constructs of the Kreger Model, a discussion about the principles inherent in a developmental paradigm for approaching childhood growth and disorder as well as the assumptions basic to the Kreger Model for use with emotionally disturbed children is in order.

Principles Fundamental to a Developmental Paradigm

The following principles speak to developmental models in general and the Kreger Model specifically for the purpose of use with emotionally disturbed and other children. These principles are inherent in developmental theories (Achenbach, 1974; Erikson, 1963; Takanishi, 1978; and others) and must be included in any model purporting to be developmental in nature. Principles inherent in the developmental approach:

1. They follow concepts fundamental to the organismic-developmental approach and the orthogenetic principle (Werner,

1957), adhering to lines of development whereby growth takes place from a disorganized and diffuse state to an organized and coordinated state.

2. Development occurs in a sequential and hierarchical pattern. Various stages can be identified by their respective quantitative and qualitative properties as growth progresses or is adversely affected (A. Freud, 1865, 1962; S. Freud, 1953; Erikson, 1963; Gesell, 1974; Kephart, 1955; Piaget, 1952; Werner, 1957).

3. The focus is on reciprocal relationships between the child and his environment (ecological), not merely how the environment molds the child.

4. The conviction is that development is complex yet organized, not simple and segmented.

Assumptions Fundamental to the Kreger Model

Assumptions basic to this model for use with emotionally disturbed children include the following:

1. The disturbed child is not a totally different being. He merely exhibits a developmental lag and/or aberrance in the rate and/or form at which he progressed through normal processes. (The term "aberrance" here refers to behavioral manifestations showing qualitative degrees of psycho-social adaptations). In other words, a ten year old boy who attacks the world of people and objects in anger when his desires or attempts to perform are restricted or

criticized is very similar to the normal toddler in his actions, thoughts and feelings. The only differences are his size, age, situations and, possibly, the exaggerated manner in which he exhibits his frustration. He is delayed (as a toddler) and aberrant (even more abusive than the typical toddler) as shown in his processes of functioning.

The following quotes support this assumption. Cowan (1978) states:

> . . . I propose that every individual difference in behavior structure and function--no matter how inappropriate it seems for a given child--is normal within some developmental context. Understanding this context helps us to know at which level to intervene when the behavior is no longer age-appropriate or adaptive (p. 364).

Herbert (1974) explains:

> . . . disorders of emotions and behaviour in childhood do not constitute "diseases" or "illnesses" which are qualitatively different from the normal (Rutter, et al., 1970).

Achenbach (1974) adds:

> Much behavior that is indeed abnormal, in the sense that it deviates greatly from the typical developmental course or interferes with the developmental progression, may be an exaggeration of the normal range of coping

behavior, due to specific parametric deviations in the child or his environment (p. 646).

2. He is not functioning within his own level due to unmet psycho-social needs. His developmental processes have been undernourished or contaminated during his emotional-social development for any number of hereditary, biological and/or environmental reasons--hence, delayed and most likely exaggerated in nature. For example, an eight year old who was neglected and abused physiologically and psychologically as a baby and now exhibits clingy, whiney, demanding behaviors and who becomes diffusely enraged immediately after any perceived loss of attention or needs is like a baby (delayed) and even more troubling (aberrant) since his disturbances consume more than just parts of his day.

Langer (1969) cites Erikson's explanation of the epigenetic principle of maturation as it relates to the etiology of emotional disturbance in a developmental sense:

> By this Erikson (1963, p. 66) means that "anything that grows has a ground plan" out of which parts (organs) emerge. Each part has its "decisive and critical time" of origin and "special ascendancy" until all have arisen and have synthesized into a functionally integrated whole. Pathological development occurs when a part "misses its time of ascendancy." The consequences are twofold: not only is that part

"doomed as an entity," but "it endangers at the same time the whole hierarchy of organs." Normal personality development is governed by a "proper rate and a proper sequence" of stages with respect to the succession of (a) the instinctual energy invested in different bodily zones, and (b) the psychosocial functions of "potentialities for significant interaction" with the psychosexual functioning of the bodily zones (pp. 33-34).

3. His behavioral patterns, as measured by both quantitative and qualitative dimensions rooted in the process of normal development, indicate the developmental baseline of his psycho-social functioning. They also indicate the stage within which emotional-social-cognitive interventions are necessary both to correct aberrances and facilitate progress from delay in development. An obsessive, compulsive, ritualistic nine year old child who holds in much expression of language, movement and other "performances" may show glimpses of more higher functioning. He may appear cooperative once in a while (probably in a rigid, forced fashion, however) or talk with one of his friends but, in general, most of his functioning is lower developmentally and his most important needs are in this stage.

Cowan (1978) addresses the necessity for an assessment and intervention format that views emotional disturbance as

an exaggeration or deficit in normal development.

> In an assessment of troubled or troubling children, we must begin with a description of the child's status on the individual difference dimensions of structure and function found in normal development. If we ask ourselves, "At what developmental level, in what context would we normally expect this behavior to occur?" the emphasis shifts from a labeling of pathology to a detailed account of the developmental structures and functions actually in use. We begin to know more about how far the child has come and what the next step is likely to be or about the current functional imbalance; then we are in a position to decide in what direction we should be heading to help the child reach equilibration. (p. 363)

4. Progressive and normalized growth in psychosocial development is facilitated by the significant adult supplying the child with appropriate, corrective childhood experiences until he has therapeutically "relived" that part of his childhood, i.e. gained the independence, confidence, perceptual discriminations, reality testing and self-control he missed as a toddler, etc. When the child has achieved his "minimum childhood requirements" of these needs he will progress in development along normal lines on his own; he will have grown internally and will have the abilities to

negotiate further growth barring continued neglect, emotional-social abuse, and/or intense and prolonged psychological or physical difficulty.

5. Programming/treatment is concerned with the developmental processes underlying behavior and not with isolated and specific behavior, i.e. attention to "excessive expression of anger via physical aggression to most other people and objects when desires or attempts at performance are thwarted" rather than to "child hitting peer 10 times in 45 minutes" is given.

6. The educator (and in a general sense, any significant adult) must attempt to understand the child's level and how the child does view the world and provide the optimal setting for facilitating normal development which includes the training of parents, teachers, siblings, etc. The adult's relationship with the child is the most important variable.

It became apparent that in order to fulfill the demands of the above principles and assumptions, one would need to design a model which must include the following criteria (L. Kreger, 1980):

1. theoretical information both integrated for practical application in areas of emotional, social and related cognitive development and codified for use by educators and others;

2. a method to evaluate the quantitative aspects of the child's psychological functioning--the amount of delay and/or aberrance from the norm in these domains;

3. a method to evaluate the qualitative aspects of the child's psychological functioning--the form of adaptive functioning, temperamental and/or socialized styles of functioning within the stage of development, processes and themes of behavior; and

4. a systematic, therapeutic and educationally based model of intervention based upon the child's actual stage and form of emotional and social functioning so that his/her developmental needs are addressed within a corrective experience which can be documented easily.

The Kreger model is a direct response to these criteria. Based on an integration of the works of Sigmund Freud (1953), Erik Erikson (1972, 1968, 1963, 1961, 1959, 1954) and Jean Piaget (1975, 1972, 1973, 1968, 1955, 1952, 1932), in addition to correlative major writings in developmental psychology in this area, i.e. Ainsworth, 1973; Despert, 1970; Fraiberg, 1959; A. Freud, 1966, 1965, 1962; Mahler, Pine, & Bergman, 1975; Robertson & Robertson, 1962, 1971, etc., the authors have constructed a paradigm that allows educators et al. to assess and therapeutically intervene with children (particularly emotionally disturbed) along developmental lines. An overview of the Kreger Model

tracing its design from theoretical integration to assessment to intervention is provided in Figure 1.

Insert Figure 1 about here.

As indicated in Figure 1, the model is based on theoretical information of normative and aberrant emotional, social and cognitive development from consistent themes found in the stage theories of Freud, Erikson and Piaget. This information is then organized into the four stages of childhood depicted by these theorists, five variables or personality parameters designed to provide for a broad and valid diagnostic view of the child and a range of adaptive functioning styles depicted by normative or expected developmental expressions of behavior expanded to include the child who, for whatever reason, displays a passive or active style or form of behavior for adaptive purposes. Descriptions of behavior patterns typifying these various stages, variables and adaptive styles are used to aid the assessor in placing the child into his functional level of development so that intervention based on these findings can begin. Following is a discussion that provides an explanation for the rationale and design of these various constructs.

Construction of the Kreger Model

Theoretical Integration

In order to portray a visual conceptualization of an integration of these theories for purposes of providing a framework for the assessment instrument, the researchers have

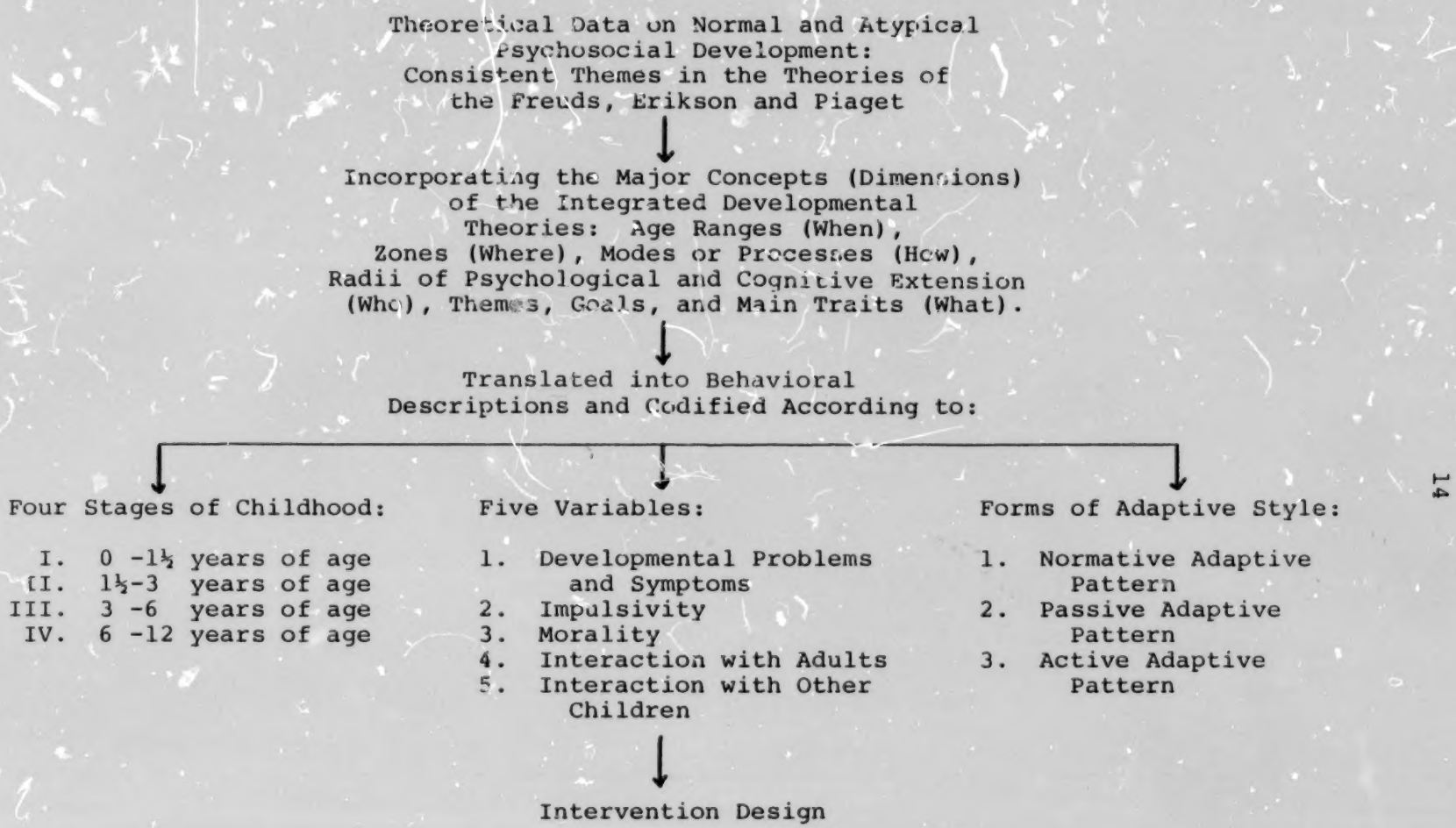
Theoretical Data on Normal and Atypical Psychosocial Development: Consistent Themes in the Theories of the Freuds, Erikson and Piaget
Incorporating the Major Concepts (Dimensions) of the Integrated Developmental Theories: Age Ranges (When), Zones (Where), Modes or Processes (How), Radii of Psychological and Cognitive Extension (Who), Themes, Goals, and Main Traits (What).
Translated into Behavioral Descriptions and Codified According to:
Four Stages of Childhood:
I. 0 -1½ years of age
II. 1½-3 years of age
III. 3 -6 years of age
IV. 6 -12 years of age
Five Variables:
1. Developmental Problems and Symptoms
2. Impulsivity
3. Morality
4. Interaction with Adults
5. Interaction with Other Children
Forms of Adaptive Style:
1. Normative Adaptive Pattern
2. Passive Adaptive Pattern
3. Active Adaptive Pattern
Intervention Design

Figure 1. OVERVIEW OF THE KREGER MODEL

designed the charts in Figures 2-5. The theoretical integration seen here in Figures 2-5 form the foundation for this model.

Insert Figures 2-5 about here.

Emphasis is placed on each of the four stages and their respective properties. By using specific key dimensions such as chronology (when), zones (where), modes or processes (how), radii (who), main traits and themes (what), one is able to bridge conceptual gaps and unify inter-theoretical concepts as they pertain to each stage and its properties. The last column indicates a "common language" for each dimension regardless of which specific theory or product is the focus of concern. Thus, one can see how interrelated and similar these three aspects of development are in the growing child. Although focusing on different areas of development (cognition and affect), each of these theorists explain phenomena basic to human functioning and basic to the same physiological abilities which govern these interrelated domains of adaptive functioning. Piaget (1952) states:

> We distinguish these two functions (cognitive and affective) because they seem to us to be different in nature, but in the actual behavior of the individual they are inseparable (indissociable)..... There is not any cognitive mechanism without affective elements....Neither is they a pure affective stage, without a cognitive element (pp. 3-4).

Theorist:	Freud	Erikson	Piaget	Unifying Concepts
Framework:	Psychoanalytic	Psychoanalytic	Genetic epistemology	Developmental
Area of Focus:	Psychosexual	Psychosocial	Cognitive	Emotional, social and cognitive
Stage Name:	Oral	Trust vs. Mistrust	Sensorimotor	Basic orientation to world
Age Range:	0-1½	0-1½	0-1½ or 2	0-1½
Zone of Importance:	Mouth and senses	Mouth and senses	Senses, particularly around mouth	Senses (receptors)
Mode of Dominance (Process):	1. Oral incorporation 2. Oral aggression	1. Oral incorporation 2. Oral aggression	Assimilation	1. Attending, receiving passively 2. Adapting reality to self actively
Radius of Relations:	Mother	Mothering figure	Constant object	One predictable person, object
Main Traits:	Id-pleasure principle	Impulsivity	Reflexive→simple coordinations of actions	World is perceived globally and only in relation to his immediate needs
	Physical, emotional neediness	Responsiveness to care and attention	Interest in sensual world (sight, sound touch, etc.)	
	Narcissism	Vulnerability	Motoric and sensual thought	Own needs, understanding are basic and personal
Theme; Goals:	Attachment Self-nonself differentiation Homeostasis	Hope, optimism, trust of self, others and world	Objective constancy Awareness of space, time and causality (basic)	Attachment and interest in world of people and other objects
	Awareness and drives			Incorporation of feelings from surroundings

Figure 2 Theoretical Integration, Stage I

Theorist:	Freud	Erikson	Piaget	Unifying Concepts
Framework:	Psychoanalytic	Psychoanalytic	Genetic epistemology	Developmental
Area of Focus:	Psychosexual	Psychosocial	Cognitive	Emotional, social and cognitive
Stage Name:	Anal	Autonomy vs. Shame and Doubt	Early preoperational	Responding and early adapting of self to world
Age Range:	1½-3	1½-3	1½ or 2-3	1½-3
Zone of Importance:	Anal, urethral, muscular	Anal and other areas of expression and retention	1. Expressive (speech, locomotion, play) areas 2. Retentive (internal symbolic thought, basic memory) areas	1. Expressive regions 2. Retentive regions
Mode of Dominance:	1. Expulsion 2. Retentive	1. Letting out 2. Holding in	1. External expression 2. Internal retention	1. Responding 2. Controlling
Radius of Relations:	Parents	Parental figures	Significant objects	Consistent parental figures objects
Main traits:	Ego-reality principle Emotional egocentricity and instability	Testing of self and world Social egocentricity and turmoil	Exploration and imitation Cognitive egocentricity and disequilibrium	Attempts to decenter gradually Egocentric (uses self as reference point; centered on own perceptions) ---emotionally ---socially ---cognitively
	Ambivalence about independence and growing up	Possessiveness with people, objects	Perceptions limited by magical thinking (animism, artificialism and finalism)	Confusion by single-dimension and personal perceptions; gross discriminations between feelings people and objects
Theme; Goals:	Acceptance of self and feelings Basic sense of reality Independence Feelings of safety (Emotional control)	Self-control, will-power Basic identity, pride Self-nonself reality Basic sense of skill (Social Control)	Perceptual and symbolic imagery Use of language, memory and physical coordination. (Cognitive Control)	Control of self and objects in newly discovered world Discrimination of gross differences between people and objects Imitation of behaviors from surroundings

Figure 3 Theoretical Integration, Stage II

Theorist:	Freud	Erikson	Piaget	Unifying Concepts
Framework:	Psychoanalytic	Psychoanalytic	Genetic epistemology	Developmental
Area of Focus:	Psychosexual	Psychosocial	Cognitive	Emotional, social and cognitive
Stage Name:	Phallic-Oedipal	Initiative vs. Guilt	End of preoperational (Intuitive)	Beginning coordination of affect and cognition
Age Range:	3-6	3-6	3-6	3-6
Zone of Importance:	Genital-muscular	Genital-muscular	1. Intrusive channels (verbal, motor, physical, etc.) 2. Intuitive channels (internal use of language, thought memory, etc.)	1. Exploring mechanisms 2. Adapting mechanisms
Mode of Dominance:	1. Intrusion 2. Inclusion	1. Intrusion 2. Inclusion	Accommodation 1. Attacking (cognitively) 2. Solving basic problems	1. Exploring 2. Adapting self to reality
Radius of Relations:	Basic family	Family unit	Small groups of objects	Significant small group of people, objects
Main Traits:	Superego Internalization of important people's values	Involvement and belonging 1. Competition 2. Cooperation	Intuition Cognitive problem solving	Accommodation ---emotionally ---socially ---cognitively
	Omnipotence, emotional assertions	Social invasions	Cognitive curiosity	Explorations, imagination
	Oedipal conflict and resolution	Sense of family membership	More discriminated perceptions	Adaptations to world and perceptual discriminations refined
Theme; Goals:	Family acceptance Valuing of self and pursuits Basic internal code of ethics	Purpose, direction Motivated social interests	Intuition(better notions of causality) Creativity, symbolic imagery Understanding of sequence and other properties of time, space and person	Self-initiation of affective and cognitive activities Internal motivation to deal with external reality of people and objects Internalization of values from surroundings

Figure 4 Theoretical Integration, Stage III

Theorist:	Freud	Erikson	Piaget	Unifying Concepts
Framework:	Psychoanalytic	Psychoanalytic	Genetic epistemology	Developmental
Area of Focus:	Psychosexual	Psychosocial	Cognitive	Emotional, social and cognitive
Stage Name:	Latency	Industry vs. Inferiority	Concrete operations	Mastery of world
Age Range:	6-11 or 12	6-11 or 12	6-11 or 12	6-11 or 12
Zone of Importance:	(Zones Neutralized)	(Zones Neutralized)	Internal concrete thought	(Psychic hibernation) Cognitive activity
Mode of Dominance:	Sublimation	Sublimation	Internal mental operations (Conservation and reversibility)	Neutralization and stabilization
Radius of Relations:	Extended family	Social institutions	Extended boundaries through decentration	Peers, school and tangible objects
Main Traits:	Interest, hobbies and activities outside of home	Interactions outside of family; peers important	Manipulations of physical objects--concrete thought	Decentration from self
	Emotional reciprocity and empathy	Social cooperation	Cognitive logic and mental operations Testing hypotheses	Views of different perspectives possible at one time
Theme, Goals:	Extra-familial involvement	Competence	Internal mental operations	Balance between internal and external phenomena
	Mastery within world	Productivity within society	Equilibration more possible; conserves and reverses thought	Achievement in social and cognitive world, harmony in emotional world
		Community concern		Stabilization of affect and cognition

Figure 5 Theoretical Integration, Stage IV

Piaget (1968) feels that affect and cognition parallel each other in the developmental process.

> There is constant parallel between the affective and intellectual life throughout childhood and adolescence. This statement will seem surprising only if one attempts to dichotomize the life of the mind into emotions and thoughts. But nothing could be more false or superficial (p. 15).

Cognition, as the authors include it in this model, refers to how a child thinks at a certain stage, how he perceives reality, what he understands, what his "knowledge" is at that time. Of course, a child's cognitive status affects his emotional and social functioning. For example, a child without object constancy who feels an object or a person ceases to exist when it is out of his field of vision (or sound if a blind child, etc.) will panic the second the caretaker (mother, teacher, etc.) leaves since he feels she is gone forever. Normally a child masters this concept by the second half of his first year but some children have not been able to do so and will react as the infant. Another example of a child being, as the authors call it, "cognitively affected," is the child who still is egocentric--himself being the center of his thoughts and only perceiving this one dimension of reality most of the time--as are most children under six. This child will appear "selfish" or "spoiled"

as he acts on only his needs, desires, feelings and thoughts. But a child like this is not yet capable of perceiving two or more dimensions of a situation, his and someone else's, and can only respond to his own.

Using this theoretical integration as a framework, a format for assessment and related intervention was created that would adhere to specific stage patterns and structures.

The Assessment Instrument

The authors' goal was to design an instrument that would use clear descriptions showing the normative or expected behavioral patterns inherent in a child's psycho-social development through age 12 as well as descriptions of those behavioral patterns that indicate the child has used exaggerated or atypical developmental strategies to cope with his world. Using the theoretical information from the charts in Figures 2-5, the consistent findings of major researchers who add credibility to these theories, and the authors' vast experiences in working with normal and emotionally disturbed children, the authors extrapolated, translated and codified pertinent information into descriptive behavioral patterns according to the following constructs:

1. The four stages of psycho-social development comprising childhood.

2. The five (5) variables chosen for this instrument.

3. The normative and aberrant patterns or styles of behavior within each stage.

Following is a rationale and explanation for the use of these constructs as well as a discussion concerning the use of behavioral descriptions in the assessment instrument. Included also is a section discussing how observations of the child should proceed. To aid the reader in understanding these constructs, sample pages have been extracted from the assessment instrument and are included in Figures 6-9.

Insert Figures 6-9 about here.

These sample pages represent the complete variable referred to as morality and span all 4 stages of development as used in the model. The entire assessment (5 variables - 4 stages) would be too lengthy to include in this article. The model is available in bookform from Northeastern University Bookstore, Boston, Massachusetts.

The four stages. As indicated, each chart (Figures 2-5) refers specifically to one of the four stages. The first four stages of development in the theories chosen for this study correspond with approximate chronological periods having specific developmental patterns through a ceiling of age 12 in childhood. According to developmental psychoanalytic psychology, mastery of these stages is prerequisite to mental health (A. Freud, 1965). Each of these stages have distinct properties and qualities differentiating them from one another.

Passive Adaptive Behavior	Normative Adaptive Behavior	Active Adaptive Behavior
Child does not perceive and/or respond to own physiological and psychological needs. He does not act to gain what he needs, but passively lets himself be deprived.	Child has no understanding of right and wrong, good and bad, yours and mine; he has no ego (reality testing) or superego (conscience). He perceives and responds merely to his own needs, both physiological and psychological. He grabs, bites and otherwise attempts to gain what he desires with no awareness of the correctness of his actions. "Rightness = what I want."	Child perceives and responds to own physiological and psychological needs with continuous, intense and immediate actions. Child urgently takes (grabs, bites) what he wants and seems to be in a constant state of need.
Child over-inhibits self by responding to adult restrictions with withdrawal or other avoidance behaviors toward the restrictive agent, i.e., person or other barrier.	Toward end of stage (at 9-18 months), child gradually is able to inhibit acting on impulses and responds to "NO" from caretaking adult (parent, teacher). Child temporarily can restrict his pleasure-seeking behavior while caretaker verbally or physically inhibits him. He attempts to avoid displeasing the caretaker.	Child cannot inhibit self when adult restricts him if personal need is present. He acts urgently and intensely to gratify self by demanding, taking and "stealing" behaviors. He seems to feel deprived most of the time.
☐	☐	☐

ADDITIONAL COMMENTS:

Figure 6. STAGE I: LEVEL OF MORALITY -- Ages 0-1½

Passive Adaptive Behavior	Normative Adaptive Behavior	Active Adaptive Behavior
Child compulsively (rigidly) complies to rules or adult controls, is overly sensitive to criticism and restrictions and/or anticipates or expects adult anger or persecution (critical ego).	Only when parental or other authority figure (teacher) is present can child discriminate in a general way right from wrong, good from bad, yours from mine, yes from no. Child can perceive limits in the here and now and can act on them, i.e., he will not take another's toy as long as adult is in the room, but when adult leaves he cannot control himself. He can restrain himself from acting on impulse if the "law" is present. He fears disapproval if he disobeys and would feel ashamed, but not guilty. "Rightness = what does not get caught or punished."	Child impulsively defies rules or authority figures. He tests, provokes and ignores limits to restraints. He tries to control the situation so that he can have his way to an extreme degree. He often blames others for responsibility rather than himself.
Child is consumed with doubt of his abilities and shame of his desires. He is preoccupied with being good and getting scolded. He is concerned with the other person over himself and blames himself for embarrassements.	Child is concerned very much with goodness, badness, rightness and wrongness in self and others. Questions about reality are posed to parental figures, i.e., "What would you do if . . . what will happen?" He tries to link cause and effect, but in a general way. He makes gross judgments by fitting together facts as they appear to himself, i.e., "you scolded me because I am bad and you hate me . . ." He blames the outside world for his faults (unintentional lying) and may project or displace his frustration, i.e., blames another for his actions or takes out his frustration on objects (rips up paper, etc.)	Child attacks and blames others for misdeeds, yet seems to invite control by acting out and testing limits constantly and angrily.
Child is obsessed with imitating adult's code of ethics precisely. He always agrees with authority figure and conforms to other person.	Child imitates the moral behavior of those important to him. He copies their attitudes and feelings, i.e., after adult hurts him for misbehaving, he believes that use of aggression is appropriate means to control, and does so with others ("monkey see, monkey do").	Child refuses to conform to authority figure's code of ethics, is angrily insistent on "doing it my way."

ADDITIONAL COMMENTS:

Figure 7. STAGE II: LEVEL OF MORALITY -- Ages 1½-3

Passive Adaptive Behavior	Normative Adaptive Behavior	Active Adaptive Behavior
Guilt permeates the child's feelings. He harshly restricts his impulses and desires to prevent ridicule or "bad" choices. He inhibits initiative, prefers not to choose, etc.	Child is developing his own internal code of ethics from family or other valuable figures. He can guide himself and restrain himself even when adult is not present as long as this morality is valued. He can anticipate disappointment from adult and forbid self to misbehave to prevent his feelings of guilt. He practices general "rules of conduct" on imaginary and real companions. He believes he causes events to occur, i.e., death, divorce, a move, etc.	Omnipotence permeates the child's actions. He feels strongly powerful in his ability to dominate and decide in an exaggerated manner, i.e., child takes on adult responsibilities. There may be no sense of guilt or superego.
Child over-accommodates to others, yet does not expect fairness for self. He feels guilty for desiring pleasure and is preoccupied with being good, i.e., usually shares with group, follows group, etc.	He can share, take turns, follow simple rules though preoccupied with winning, and empathize with others. He is concerned with the fairness of "law" with others as well as himself. He expects others to obey rules and be as sensitive and accommodating to him as he is to them. "Rightness = what is valued by others."	Child desires others to accommodate to his initiated activities and powerful conquests without regard for theirs, i.e., seldom shares, follows, etc. Child will cheat to be the first or best, etc. regardless of harm to others.
Child fears rejection from significant social agent (family, TV figures, teachers). He stifles initiative and own thoughts and agrees without hesitation to values of others. He cannot make own decisions, choose alternatives or take own initiative for fear of rejection from group.	Child needs to belong and thus identifies with the conscience of the family or other valuable social agents, i.e., TV. He conforms to their moral system, accepts and respects their beliefs, feelings and behavior and internalizes their code of ethics.	Child "doesn't care" what others value and asserts self with power, dominance and status seeking. He disregards the freedom of choice and initiative of others in his group.
☐	☐	☐

ADDITIONAL COMMENTS:

Figure 8. STAGE III: LEVEL OF MORALITY -- Ages 3-6

Passive Adaptive Behavior	Normative Adaptive Behavior	Active Adaptive Behavior
Child slightly over-conforms to the moral codes of his society or peer group. Most problems are regressions (see I-III).	Child (conserves) conforms to the laws of his society, peer group. He is concrete and "legalistic" in his approach to rules of the status quo. He strives to maintain tradition and convention. Child is aware of mutual benefit or gain derived from cooperation, reciprocity (reversibility), and empathy towards others. (He cannot view logical, abstract or democratic universal "law" at this stage.) Child begins to develop sense of intentionality, i.e., the reason behind an action is of concern. "Rightness = the intention or meaning of an action." (NOTE: Behavioral theory functions from Stage II or III, not IV.) Child can understand two or more tangible perspectives at one time, be objective to his and other viewpoints and consider different frames of reference in his judgments of situations.	Child has some difficulty maintaining the moral code of the status quo in his society or peer group. Most problems are regressions (see I-III).

ADDITIONAL COMMENTS:

Figure 9. STAGE IV: LEVEL OF MORALITY -- Ages 6-12

> For Freud, Erikson, and Piaget, stage is more than a marker indicating the probable occurrence of particular behaviors. Rather, it indicates that the personality, intellect, or whatever realm is being considered is structured in a particular way. The concept of structure refers to the way elements are interrelated; it includes not only the elements but also the relations among them. Thus, being in a particular stage implies not only having certain behavioral capacities but also having a certain pattern or structure of behavioral capacities. (Lipsitt & Reese, 1979, p. 31)

Together, they represent an epigenetic principle of maturation (Erikson, 1963). They address certain patterns of behavior describing how a child may function. How he functions emotionally, socially and cognitively depends on his physiological and psychological capabilities at the time. Whether the child passively takes in or actively rejects having his needs gratified (stage 1), aggressively expresses or holds in an attempt to control his environment (stage II), assertively intrudes or cooperatively includes in his motivation to initiate activities (stage III), or intelligently weighs an entire situation before acting in an organized manner in his efforts towards mastery (stage IV), depends on his organismic or developmental age, i.e., the stage in which he functions.

This assessment instrument translates these psychologically based processes of the child's functioning into stage-specific, descriptive categories of behavior, not merely isolated and out-of-context behavioral items as so often found in behaviorist-learning theory. Thus, the qualitative dimension of behavior is included as well as the quantitative dimension. This allows for a discrimination of each stage from another. Schell and Hall (1979) explain:

> A stage theorist would agree with a proponent of behavior-learning theory that a change in amount, frequency, strength, or duration of a behavior shows continuity. But when ways of behaving that have an inherently new organization emerge, the stage theorist would point to discontinuity in development. This discontinuity indicates qualitative changes in behavior and functioning and in their underlying processes (p. 42).

Based on this, the purpose of The Kreger Model is to address the stage related qualitative processes of the child's functioning to insure that the motivation for or affect behind the behavior is being considered and treated. For example, when one looks at the motivation behind aggression in a developmental sense, one needs to know whether the child's "aggression" is one of frantic and frightened panic at loss of orientation (stage I), anger at thwarted

attempts to perform or at stifled desires (stage II), or competitive need to be better than others (stage III). One would need to look at processes and themes--at how the child exhibits aggression. Is it with diffuse narcissistic rage at no particular target (stage I), at a person or object with specific anger shown by physical and verbal abuse (stage II), or focused at the person with caustic verbal remark or manipulative behavior (stage III)? Also, is there subtle aggression in a passive person shown by turning the above mentioned feelings against oneself or into passive aggression? Self stimulation, self abuse, self ridicule in humor, etc. are some examples of the latter. One would need to put these behavioral patterns into a stage context before attempting to treat as a single entity.

The five variables. The following five variables were selected for this assessment instrument:

1. Interaction with other children.
2. Interaction with adults.
3. Morality levels (right-wrong concepts, conscience).
4. Impulse levels (frustration tolerance, delay of gratification, defenses, etc.).
5. Developmental Problems and Symptoms (well-established clinical entities representing stage characteristics).

These variables were selected for the following reasons:

1. They are accessible to observation by the adult.

2. Two of them, interaction with other children and adults, address the social-interactive component of the child.

3. The morality (superego) and impulse (id) variables provide insight into the child's emotional levels of behavior. Included in these are measures of the child's level of frustration tolerance, ability to delay gratification, defenses or adaptive mechanisms used when frustrated, and level of value and ethical standards (conscience).

4. The developmental problem variable looks at symptoms which both arise at certain periods and are indicative of specific stage themes of behavior.

5. Together, they provide the evaluator with a comprehensive and valid profile of the child's overall developmental status in the psycho-social realm.

In addition to the five major variables comprising the assessment, other "sub-variables" are consistently addressed and intertwined throughout the context of the descriptions. These include the role of play, communication, social skills, and adaptive (defense) mechanisms.

The styles (forms) of behavioral patterns. These styles (forms) are represented in the instrument by the

following schematization:*

Passive Adaptive Pattern ⟵ Normative Adaptive Pattern ⟶ Active Adaptive Pattern

The middle category (Normative) represents behavioral patterns that one would expect most of the time from children who are actively negotiating the development tasks of a given stage, regardless of his chronological age. If the child's needs are met for that stage then the child will master the tasks of that stage and progress into the next. However, if the child's needs are not being met for that stage, he often will adapt to this conflict via the use of behavior that one finds in the Passive or Active Adaptive

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* While the use of the various styles of behavior, i.e. Passive Adaptive, Normative Adaptive and Active Adaptive, are unique to this project, one can find numerous citations in the literature which address various styles of personality behavior having like meanings. Achenbach (1966) uses a classification system which refers to Internalizers and Externalizers; Eysenck (1967) conducted much research on the personality styles on Introversion and Extroversion. Neubauer and Flapan (1975) show ranges of childhood behaviors as being characteristic, expected, typical to uncharacteristic, unexpected, untypical or pathological; Thomas et al. (1963, 1968) refer to the Easy Child and the Difficult Child as determined by nine (9) temperamental qualities having retentive (passive) and expressive (active) ranges of behavior. Others, in their writings on socioemotional development in childhood, discuss the various styles or patterns of behavior found in children (Despert, 1970; DiLeo, 1977; Fraiberg, 1959; Herbert, 1974). However, Erikson (1963, 1954) provides the clearest explanations of these styles of behavior in his discussions concerning the various ways children can adapt when their needs are not being met at any given stage of psychosocial development, e.g., the child in Stage 2 who may use the adaptive style of impulsive defiance or compulsive compliance.

extremes of that stage.* This will restrict the child's completion of the tasks of that stage. It is precisely this delay (normative column) and/or aberrance in delay (passive/active) which explains the "disturbed" behavior of the older child in emotional conflict. That is, when the child is older and exhibits either normative or extreme active and/or passive forms of earlier stage behavioral patterns, this indicates delay and/or aberrance in his psycho-social development. For example, all toddlers may aggressively express themselves with explosive, angry, negative and uncoordinated performances at times. They also may control themselves to the degree of compulsive holding in of affect, retentive inhibition of social contacts and restricted exploration and curiosity at times. Their goal, whether active or passive, is to gain control over their environment. However, if a ten-year-old child functions only in the expressive mode or retentive mode (or anywhere in that stage), a problem exists. The child is larger, older and in situations where his behavior is not constructively

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* It should be noted that it is not uncommon for the normal child to show behaviors that span the continuum of Passive-Normative-Active styles of behavior while negotiating certain stage milestones. It is when an aberrant or exaggerated style predominates within a stage that concern is warranted. Being cognizant of the rate, intensity, and duration of the behavior becomes an important diagnostic issue here (Hutt & Gibby, 1959).

adaptive. His explosions, tantrums, negativism, messiness, etc. are cause for interventions to facilitate the development which was detoured and more age-appropriate functioning. We do this by translating stage indications into needs which must be met at this time for the child to continue growth from his interrupted status (L. Kreger, 1980).

The use of these three styles of adaptation is consistent across all of the four stages and five variables used in the assessment.

The descriptions of behavioral patterns. Unique to this particular assessment design are the vivid descriptions of behavioral patterns whose purpose is to collectively typify the child who is fixated or regressed to a specific stage and/or style of development. The behavioral descriptions adhere closely to the key dimensions, i.e. themes, processes, goals, etc. of each stage. They represent the various styles (passive-normative-active) of behavior found in children. The descriptions are spread across five variables (impulse, morality, interaction with other children and adults and developmental problems and symptoms). These descriptions are an extrapolation of the basic concepts portrayed in the theoretical integration (Figure 2-5) as well as supportive findings from the research which help support and verify these theoretical constructs. Tedious attention was given to

the interpretative process involved in translating the theoretical concepts and related research findings into specific stage themes and styles. All descriptions adhere strictly to these findings in the areas of socio-emotional and related cognitive development.

The rationale for using descriptions of behavioral patterns relates to the purpose of the assessment: to measure both quantitative and qualitative aspects of the child's actual level (degree) and style (form) of functioning in the area of socio-emotional development. Unlike criterion referenced or single-item norm-referenced measures which select isolated and out-of-context skills or behaviors, the descriptive assessment captures the child's overall and in context themes, processes, and styles of expression and places this behavior into its proper perspective. This knowledge of the child is necessary for an intervention that intends to meet the specific developmental needs of the child and facilitate progressive and internal growth. Should the evaluator need/wish to add comments for any other purpose, space is provided at the bottom of each page of the assessment.

Observing the child. The assessment portion of the model relies wholly on the observations of the user. The authors strongly suggest the following for reliable and valid evaluation of the child:

1. Be familiar with each child, his day-in and day-out patterns of behavior in many contexts, his functioning without props (adult monitoring, controls, external rules, extra attention, etc.); his own reactions to situations with adults, with children, when frustrated and at what, when involved in dilemmas of morality; his unique developmental symptoms and/or problems. These must be observed consistently.

2. Evaluate the child with such consistent and in-context information after a period of careful observation of the child alone, in play with others, when with adults, when working on tasks, etc. to assure reliability.

3. Allow the child to exhibit his own true level and style of functioning, ability, and desire without being pushed to "act more appropriately." Only with such information can one assess true psychological functioning.

4. Make judgements about his functioning level and style after a period of at least several days and different experiences and observations (one need not have the child present when doing the assessment) based upon such information showing his patterns of behavior regardless of little variations in the environment to ensure reliability.

5. Evaluate the child in areas accessible to the observer and on areas one purports to assess, i.e. if social, then social interactions to assure validity.

6. Have others familiar with the child assess him for further checks of reliability and validity; compare and contrast findings across settings (home-school).

With these points in mind, one simply needs to read through the various descriptions of the assessment to find the cluster which most describes the child's mode of behavior in a given setting. It is not expected that the child will show all the behaviors listed in any given column (passive-normative-active) but rather that the behaviors of a given column taken together typify the child's overall level and style of functioning. At times also, evaluation of a child may show different degrees (levels) and adaptive styles across the five variables. In these cases, the examiner should address the baseline of functioning and closely investigate whether certain environmental or ecological variables may account for this spread.

Once this information is ascertained, the user can then profile (provided in model) the child according to stage dominance and adaptive style and refer to the intervention portion of the model for an individualized therapeutic program designed to meet the specific developmental needs of the child. In cases, however, where a given child may score at different levels on different variables, one would direct the intervention at the lowest development level scored.

Developmental Intervention for Facilitating Development in Emotional, Social and Related Cognitive Functioning

Translating Assessment Information into Program Guidelines

The purpose of this part of the model is to provide parents and professionals significant in the lives of disturbed children with a means for designing developmentally appropriate and therapeutic intervention programs. This model is unlike many "recipe-like" models which dictate exactly how-when-what to do to elicit or stifle a specific behavior and unlike criterion-referenced designs which link one behavior or task to a given strategy, etc. The Kreger Model describes necessary overall, general and specific needs of children whose adaptive functioning is within a given stage and/or style, but allows for adaptation by the adult to specific needs, interests, age values and abilities of a given child. Only the adult familiar with the child can know exactly how to approach a specific situation most meaningfully.

After assessing the child's functioning in the various areas (five variables) and obtaining a summative profile of his baseline abilities, one has pinpointed the starting point for meeting needs and for the interventions.

Directions for Intervention Design Use

First of all, the intervention design is divided into three major areas for each stage--Interactions with Adult, Interactions with Other Children and Cognitive and Related Educational Activities, in addition to sections for Special Needs. The first three areas pertain to any child who functions within that stage in that area, i.e., Stage II in Interactions with Adult for both Assessment and Intervention. The Special Needs section offers corrective experiences specific to identified styles of functioning and/or developmental symptoms and problems. Thus, in addition to using the more general interventions in the first three areas, one should utilize also the specific interventions which match the child's special difficulties.

Preceding each stage is an "introduction" summarizing the various types of children who function in that given stage, the affective goals one should strive for which the child has not yet been able to negotiate and an outline of fundamental needs classified into who, where, how and what.

As stated before, the adult must be able to adapt these conceptually and practically oriented intervention needs within his/her own setting. But it is very important to remain within a stage until it has been negotiated successfully and fully by the child as determined in the assessment. For example, if a child is in Stage I, the

adult must not use a rules-consequences approach, expect performance on specified tasks, require conformity to limits even if they are reasoned through, etc. since these are yet beyond the ability of the child. An attitude of patient and therapeutic endeavor will be noticeably successful in short time, and one must not feel that he/she is sacrificing precious time or that he/she must continue to push the child to "catch up" on academic levels, etc.--these will come in time but only when psychological needs have been met. Then they truly will be incorporated into the child's understanding, functioning and internally motivated system, not merely exhibited in a rote, externally-pressured fashion. The cognitive areas are meant to fully develop the child's ability to think and understand in ways which affect both his psychological status and his ability to conceptualize. Thus, academic progress will be obtained in a meaningful and complete manner.

Following is a verbatim description of the suggested programmatic interventions which are to be used with the child functioning at a Stage II developmental level. (See Kreger Model, pp. 47-69). Modifications of this portion of the model are currently underway for purposes of improving its format for adaptability by professionals and parents.

The Child in Stage II.

This child, for whatever reasons, has not gained the basic nutriments for realistic self-image and self-control. He has not been able to express and structure the "goings on" within himself and the outside world by means of basic (still self-centered), personal and perceptual discriminations (inner vs. outer states, subjective vs. objective states). He exhibits either passive compliance, toddler-like affective and cognitive confusion in thinking or active defiance and is in need of interventions geared to facilitate appropriate emotional-social development. Fundamental to his needs is attention to the following requirements:

Radius of Significant Relations (Who--Adult): A couple of reliable and fair parental figures to both encourage and limit his autonomy (independence).

Social Level (Who--Other Children): Parallel play beside and imitation of one safe peer.

Zones of Importance (Where): Anal and other areas of self-expression and self-control; bladder and bowels, speech, locomotion and "active thinking."

Modes/Processes of Functioning (How): Anal and pre-operational expressing and controlling; egocentrically discriminated perceiving.

Goals of Stage (What): Basic personal and perceptual reality testing (ego), individuation, confidence, will power and self control.

Illustrative General Needs

Interactions with adult. Fair and reliable parental figures to define and explain reality, clarify external situations (from self-centered perceptions) and develop in child basic skills to discriminate among perceptions, i.e., safe-unsafe, good-bad, right-wrong, yours-not yours, circle-square, one-two; concerned and consistent adults to act as child's ego and superego without expectation that child can sustain this if alone.

Encouragement of separation and independence by affection and praise; realization by child that growing up and becoming less dependent does not imply losing adult love and attention; child learns to master and cope actively, i.e., with regard to toileting, talking, walking, etc. to gain adult's approval.

Adult encouragement of child's exploration, excitement over child's new skills and abilities whether or not child returns for "re-charging"; reflecting a "I'm so proud of you . . . Your are so capable" attitude.

Acknowledgement and respect of feelings (anger, etc.) in specific situations while first finding out why and then channeling feelings constructively, i.e., "I would be mad too, but instead of . . . why don't you . . .," without hurtful criticism of child or shaming of his behavior.

Fair and reasonable consequences to child's wrongdoings; helping child accept responsibility for own actions and understand why they were wrong and what alternatives are available; do not punish with aggression but teach human respect. Use of immediate, short and connected consequences, i.e., child spills peer's milk, he cleans it up and hears alternatives to this episode, etc. without adult loss of control; unreasonable or disconnected punishment (sit on chair for 15 minutes or have someone else take child away).

Patience during child's imperfect attempts of independence (in movement, language, perception); criticism and control by adult kept reasonable; admiration and tender alternative-giving, rather than belittling or shaming his messes, mistakes, etc.

Support, not teasing or anger, through times exhibiting child's magical thinking and confusion; clear explanations of reality to reassure child of the safety and order in this world.

Emphasize to child that he can think a bit ahead, can choose from alternatives, is lovable and can use language to help express his needs.

Practice with control issues; time for child to be in control vs. time for trustworthy adult to take a stand; allowing child time to direct his life and also time when "adult knows best".

Admired adult figure for child to imitate and model; actions, words and attitudes for him to copy consciously; judiciousness of parent figures retained by child in his/her presence, expecting morality exhibited only as long as adult present.

Concrete reflections of child's worth and short-term growth, i.e., verbal praise and affection, photos, height charts, progress graphs to help concretize success by a couple of consistent, important adults.

Few, fair, gentle and firm limits to independence given (to neutralize id) with personal reasons for child to understand and with permissible alternatives, i.e., "You cannot jump on the bed because you could hurt yourself, but you can jump on the lawn."

Choices and alternatives offered to child both to encourage his autonomy and problem-solving and to limit inappropriate independence, i.e., "Do you want your potatoes mashed, cut or sliced? . . . After you put on your shoes, do you want to go on the swing or play a record?"

Mastery of child's separation anxiety by reassuring him (with experiences) of continued good care by familiar adult and of adult's return, especially during crises such as divorce or other separations.

Vivid emotional and personal praise of child's prosocial behaviors and clear modeling of these at all times.

Interactions with other children. One safe child at a time to play or work beside, to observe and imitate (Simon Says); seating with one "model" child.

Opportunities to assert self, while not hurting other child; another child to safely entice him to engage in social play.

Privileges and limitations of child's autonomy monitored by adult; child assisted by adult to enjoy self while not hurting another child, to be "boss" at one time and be the "follower" at another.

Gentle pointing out of different points of view to child who now can perceive only his own with the realization that he can act on this only in adult's presence (no internal code), i.e., knowing he would take desired toy from peer without ability to "feel" for peer unless adult present.

Help for child to take active role in assisting a less able child to express, structure or understand a situation; practice making sense of world while in role of "doer," rather than role of "done to," skill practice by teaching a peer a skill, a behavior, etc.

Cognitive and related educational activities. Expressive activities: opportunities for vigorous locomotion (running, climbing, dancing, jumping, swinging, throwing), language (private speech during private play, singing to nursery rhymes and other catchy phrases, loud use of voice during

appropriate times) and emotions (excitement, disapproval, anger, etc.) allowed within constructive play.

Opportunities to oppose (say "no"), be messy (in sand, water, clay, paint, play), and loud (bang on instruments or pots, sing out loud, rough it in gym); time and place for exploration and experimentation (crawl through box, pour water from one container to another, use science basically); choose from reasonable alternatives (say NO to one thing and YES to another).

Structuring and coordinating activities: time to dirty containers and then clean them, to tear paper and then paste on a form, to cut out letters, then classify them correctly; retentive-type hoarding or classifying activities such as basic seriation of size (stack small to large), sequencing of time (first we eat, then rest, then go outside), classification (by color, shape, size, function) and recognition of order (circle, square, circle, _____?); use of single and physical characteristics of object, i.e., color or shape. At this time child does not perceive all aspects of a situation at one time, i.e., box is big, not necessarily empty too.

Perceptual discrimination activities with child's own physical involvement, i.e., climbing over, under, beside chair; discriminating visually (color, shape, size), auditorily (loud vs. quiet, high vs. low sound, etc.); social

interaction to decrease egocentric perceptions, i.e., he thinks chocolate ice cream is best--another child likes vanilla; he wants toy--another child had it first, he can use another and know that in five minutes he will obtain toy; helping him attend and discriminate clearly to sensations in his world.

Increasing use of language: receptive activities (listening to songs, tapes, stories; labeling of objects, sounds, functions) and expressive activities (singing, copying or repeating phrases and songs, telling basic information to interested person) to increase both internal thought via symbols and use of language to communicate while decreasing need for impulsive actions to "speak."

Decreasing magical thinking by helping child see that world is not as chaotic and uncontrolled as it appears; perception of child's confusion and gentle explanation by active mastery of fear, i.e., show no monsters under bed; play fireman so child understands why siren is loud, that driver is in control of starting and stopping truck; observation of adult and practicing reality in his own play. Encourage child to take active role in mastering fear with safe, reassuring experiences at his own pace.

Use of toys such as a toddler climber, bicycle, sandbox, water basin, large beads to string, toy cars and people and big picture books or other muscular-perceptual activities for older children.

Science activities of "messing and structuring," i.e., red and yellow paint = orange; one big pitcher of sand will not fit in one small cup; hot and cold water = warm; flour and water and salt = playdough.

Body image awareness by use of mirrors, tracing (body, hands, feet), photos, height charts; positive nicknames (Kevin Quick) and clear reflections that child gets bigger and smarter every day.

Play to develop reflection before action: help child state problem, clarify feelings, anticipate consequences of his actions, think of other alternatives and practice these for future use; time with adult to gain such information through good example (not impulsive and angry revenge by adult!).

Encouragement of child to anticipate consequences and feel in control of life by reducing impulsivity and by developing thought through structured experiences with spatial and temporal seriation (where and when concepts), language and other symbolic imagery (use of signs . . .) and classification (discriminating differences in stimuli and grouping); experiences to master shame, doubt and confusions.

Explanations of reality related to child, i.e. "if you go up into that tree you could fall and hurt yourself because . . . but the climber isn't that high and is safe for two-year-olds . . . I can't play now because I am sick.

Remember when you had the flu and . . ."; focus onto adult's concern with child rather than onto a punitive or rejecting external world since he is egocentric and only perceives his own needs.

Allowances for child to control situations and adult organization of situations for child to follow when he can't himself.

Illustrative special needs. For child with toileting, talking or locomotion problems: (1) if "under-expressing," child needs gentle and consistent reassurances that his "performances" are appreciated as well as extreme leniency by parental figures regarding issues of control, i.e., support and continued affection when child tries to express himself with sphincters, language or movements; or (2) if "over-expressing and under-controlling," child needs gentle, consistent and firm structuring by parental figures to limit his "performances" to specific places, times and amounts as well as external controls (stopping child) when necessary, i.e., praise and reinforcement when child can coordinate and control these areas of his functioning, i.e., "I cannot let you . . . it is not safe and I would not let anyone do that to you . . . you can . . . however."

For child functioning with extreme magical thinking, i.e., psychotic child: adult to help him gently communicate feelings and thoughts, i.e., read his cues with sensitivity

and give words for this, develop ability to anticipate real cause and effect (ask what will happen if . . ., suggest the train of events in a situation, sequence objects in predictable order), reinforce his successful and active verifications of reality, and expose him to multisensory objects with interrelationships (close eyes, feel object, tell what it is, smell to verify, etc., as in Feely Box), as well as integrating feelings and thought in daily experiences.

For children who overaccommodate, i.e., schizophrenic children: gradual exposure to safe, secure, more structured activities, i.e., first allowing child to imitate another or otherwise copy the outside world with feeling-state or action → gentle encouragement for child to perceive and express his own feelings into an "acceptable" reaction → pleasurable excitement at child's new-found ability to direct his own functioning; first, adult may imitate child to introduce disequilibrium and then encourage child to provoke adult's play further by child's taking active rather than passive role; sensorimotor play to increase child's awareness of own bodily sensations rather than focus solely on outside perceptions; use an unstimulating environment, focus child on own senses and movement (Cowan, 1978).

For over-compliant child, i.e., obsessive-compulsive child who is over-controlled by outside world: extreme

tolerance of child's independence-seeking behaviors, encouragement of child's lead, admiration and affection for child's ability to act on own by parental figures; less rigid structure in environment and by people to child's functioning (more relaxation).

For over-rebellious child, i.e., over-controlling of outside world: extremely caring but firm, reasonable limits by parental figures to child's unsafe assertions; persistent, fair and explainable structuring of child's disorganized or destructive actions; channeling anger into pleasurable experiences by mastering losses of control; constant reflection of need for safety to him, others and objects that adult will control when he cannot.

Note: Being "over-powered" is especially <u>detrimental</u> to a child in this stage and should <u>not</u> be used as a mode of intervention, i.e., physical punishment, aggressive handling, angry rejection, emotional "banishment," etc.

As can be ascertained from reading the above, the user must learn to creatively adapt his/her available environmental and personal resources in an effort to maximize these recommended interventions. As indicated previously, this is not a recipe model providing tailor made responses to specific overt behaviors but rather a curricular and interpersonal design aimed at providing the disturbed child with a means for therapeutically "re-living" missed or

contaminated sequences in development. Remember also, the goal of the Kreger Model and any program aiming to help facilitate normalized development in children is not to elicit rote, disconnected, unspontaneous or unintegrated behaviors; it is not a deficit model which tells one what a child cannot but should do nor is it a behavioral model which attempts to elicit appropriate and decrease inappropriate behaviors. This model meets the adaptive true needs and levels of the child and facilitates the child's progressive growth so that he can understand, respond and function both internally and externally at a higher level.

Designing Individualized Educational Plans

The Kreger Model has easy adaptability for the design of the child's Individualized Educational Plan (IEP). As explained below, it adheres closely to the following mandated components of the IEP:

1. A statement of the child's present level of educational performance which must include social and emotional functioning. (The assessment portion of the Kreger Model measures the developmental level (stage) and adaptive style (passive/active) of functioning of the child. Other assessments do not yield these findings nor offer specific quantitative and qualitative information).

2. A statement of annual goals for this child's educational program including affective-social skills.

(Annual goals can be established by referring to general goals of each stage found on the Introduction sheets for each of the four stages prior to general and specific interventions.) In this model, the professional is certain that the child is "ready" developmentally for the specific emotional-social goals since he/she has determined which stages were and were not negotiated successfully through the assessment format.

3. A list of short-term objectives stating what the child can do, under what conditions and with what degree of success. (The Intervention portion of the Kreger Model offers numerous techniques and activities specific to the needs of a child in a given stage. Included are suggestions for helping the child in his interactions with adults and other children, with his cognitive and other related educational activities as well as specific special needs for a given child. Since these interventions are related directly to the child's needs, short-term objectives can be extrapolated easily.)

4. A statement of educational and related services needed by the child and a description of the extent to which the child will participate in a regular education program. Justification must be given for the type of educational placement the child will have. (The Kreger Model makes specific suggestions concerning the child's placement and

need for certain educational and related services, i.e., a Stage I child typically requires a closely monitored 1:1 relationship with a caretaking adult during his school day and should not be expected to cooperate or compete with peers yet. This ratio of caretaking has great implications for class placement and types of services.)

5. An IEP must contain evaluation criteria, schedules for determining if the objectives have been met, and a date for the initiation and alteration of services. (The Kreger Model has ongoing evaluative measures built into its design in that the child is to be reevaluated every three or four months to measure developmental progress. The results of these evaluations can be used to determine whether the objectives have been met and whether any alteration of services is warranted. Unique to the model is the ability to show both qualitative forms of developmental movement and quantitative amounts of developmental gain.)

The following section discusses how these gains, or lack of them, can be documented.

Record Keeping and Monitoring Progress

The Kreger Model has ease of documentation built into its design. The Assessment portion will yield various types of information necessary for record-keeping, reporting and monitoring of both the program and individual child. Qualitative and descriptive information is provided by the

assessment, i.e., "this child relates to other peers most of the time with unprovoked physical and verbal aggression, criticism and tormenting and other hurtful patterns of behavior without the ability to regard their feelings, the results of this aggression, the effects of his behaviors or the true intent of his misdirected frustration at his not being more capable or confident, etc." Quantitative and statistical data are available also with this design, e.g., "in September the child typically functioned within the active style of Stage I--as an unattached, impulsive and frantically needy child--however, in May he functioned within the normative style of Stage II--testing his newfound identity and ability by alternating oppositional reactions to outside controls and the needing of recognition and praise for his verbal and motor performance . . ."

Although the competent and dedicated educator will find himself/herself assessing the child and adopting intervention designs in an on-going manner, one easily can document for record-keeping purposes in a periodic fashion, i.e., in September, January and May. Early in the school year documentation will, no doubt, highlight the child's actual functioning and needs where later notes will point to progress made and intervention changes. The Profile is helpful when graphically representing change, i.e., it exhibits the child's functioning in each of the five variables (stage and

style) at each different time period. It is useful for both administrative and personal reasons to keep such data. Necessary are records of individual children's and program's progress over time. Also necessary are concrete reminders of the child's developmental status especially when "progress" often elicits more "disturbing" behavioral patterns. For example, a quiet, unassuming withdrawn child (Stage I, passive extreme) may become negative, bossy and loud. It is easy for some to feel, "Oh dear, he never was as much trouble before . . ." but the Profile summary of assessment data shows the progress in developmental lines whereby the child has become aware of the outside world and is engaged with it now. This also may be helpful in showing a parent the progress made by the child and indicating the next set of patterns to anticipate, encourage and deal with therapeutically.

Further Research Implications

In addition to application of this theoretically based developmental model for assessment and intervention in the emotional-social realm of disturbed youngsters, this model appears to have more far-reaching possibilities for use with other populations and in research exploring other phenomena. A brief list of such potential studies follows:

1. Parent and teacher training in the prevention and remediation of emotional disturbance in children.

2. Evaluation of teacher and/or program effectiveness based on individual children's progress.

3. Relevance of the school curriculum as it relates to children's "internal curriculums."

4. The measurement of social, emotional and cognitive developmental functioning in children with mental, physical and/or other handicaps.

5. Studies aimed at gathering data on cross-cultural and gender-related patterns of behavior.

6. Establishment of correlations between etiological factors and the child's level of delay and/or style of aberrance.

7. Evaluation of the emotional, social and cognitive levels of day-care children to compare with those of children with one constant caretaker.

Summary and Discussion

Construction of the Kreger model was in direct response to the authors' perceptions of the dire need for a developmental assessment and intervention design which would offer adults who are deeply involved with emotionally disturbed and other children a comprehensive and systematic method for providing them with a lasting "corrective" or "re-educative" therapeutic program.

Having worked for many years as educators with a wide variety of emotionally disturbed children and adolescents,

it became apparent that to be therapeutically effective one needed a means for placing disturbed behavior into its proper perspective. By recognizing that true emotional disturbance is actually a manifestation of unmet developmental needs and that these children behave in aberrant fashions as adaptive responses to real or imagined threats and due to not having mastered critical psycho-social milestones necessary for sound ego development, one realizes that any program which aims to enact lasting internal changes must address these faulty or aberrant processes of development. Unfortunately however, existing educational programs for these children display a real naivete in their diagnostic and intervention designs in this regard. Excepting the now somewhat antiquated works of Fritz Redl and Bruno Bettleheim (which addressed disturbance in a psycho-dynamic sense but lacked systematic cohesiveness in assessment and intervention design as they relate to aberrances in the developmental process), the field is void of any meaningful, systematic correct interpretation or application of the integrated works of the major developmental theorists. This unfortunate lack of "cross-fertilization" between education and psycho-analytic and developmental psychology is documented in the following remarks:

> Having been involved for several years in teaching developmental and clinical courses to undergraduate

> and post-graduate professional students, I am very conscious of how little cross-fertilization there is between the developmental and abnormal branches of psychology. Such mutual exclusiveness is particularly unfortunate when it comes to the assessment, understanding and modification of emotional (i.e., psychological) problems of childhood. (Herbert, 1974, in Preface)

> Despite the importance of development for all aspects of child behavior, there is no single, clear-cut developmental model for psychopathology in children. . . . Attempts have been made to reconcile the Freudian ideas of development with Piaget's work but there has been little extension of Piagetian theory to psychopathology in children. . . . The really important work in bringing the concepts of development to bear on psychopathology in children remains to be done. (Achenbach, 1974, pp. 48-49)

The Kreger model is meant to be a step in this direction. Until we come to understand the manifestation of emotional disturbance in childhood in its proper developmental perspective--as we do in other areas of exceptionality--we must question seriously the efficacy of existing programs and the methods used to "educate" or treat troubled children. Anything less is totally inadequate to the

conditions we seek to remediate. Personality factors are more elusive and complicated to restore compared to more "concrete" phenomena such as physical conditions. But it is possible to address these factors with a solid knowledge of developmental growth and disruption. We must have such knowledge and such experience with our own strengths and limitations. For it is imperative with disturbed children especially, that we have the capacity to identify with the child without loss of our own ego, that we wait patiently for internal growth to cause external behavioral change rather than try to force change anxiously or retaliate for the child's disruptive behaviors, that we realize how no two children are identical and that each requires adaptation on our part to facilitate progressive growth rather than use a narrow, rigid approach with all. To know when to encourage and when to discourage or when to give unconditionally and when to limit with structure or when to welcome what may seem to be regression but which is progress, i.e. the autist who becomes "overly" attached or becomes oppositional, requires commitments to such study. Only then can one see vividly why a disturbed child, by definition of his exceptionality, belongs in a setting which is <u>first and foremost</u> emotionally therapeutic and secondly "academic." For, as is seen in developmental assessments, he is <u>not</u> even at the stage where he can sublimate his energies

into academics without concern for emotional security. Thus, any education must be within a therapeutic environment. Then, academics can and do flourish.

The role of the Special Educator must be looked into further. Is our goal to promote academic progress, however rote or unpleasant or disconnected, and discourage expression--and treatment--of emotional handicap? This topic will be explored in another article in progress at this time.

Limitations

The Kreger Model has been used successfully with several children in various settings by the authors. A book of full case studies organized to show history and etiology of the conditions, assessment procedures, intervention designs and how progress took place over time within both individual and group settings is being completed at this time. Also, the model is being used in a few school systems which are being followed in order to obtain data on this population. However, more closely followed field-based applications would be very helpful in order to have complete and organized studies of the use of this model. The authors are hoping to begin this part of their work in the near future in systems where more complete in-service training of staff, direct involvement with children, follow-up of the model's impact on individuals and programs will be possible.

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